Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MID-TOWN SURGERY CENTER LLP
C/O GILBERT & MAXWELL PLLC
PO BOX 1984
HOUSTON TX 77251

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name: Insurance Carrier #:

Carrier's Austin Representative Box

Box Number 47

Respondent Name

ZNAT INSURANCE CO

MFDR Date Received

OCTOBER 29, 2003

MFDR Tracking Number

M4-04-2991-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is Mid-Town's position that this facility correctly and appropriately coded and billed for the treatment(s) and/or service(s) performed on the above referenced patient and date of service. Each and every item and service necessary for this medical care, including pre-operative and post-operative care, were documented thoroughly. …the insurance carriers must comply with TWCC Rule 133.1(a)(8) which clearly defines 'fair and reasonable' as the lesser of usual and necessary charges, MAR or negotiated contract. Your reimbursement rate is not in compliance with this requirement or definition of 'fair and reasonable'. As stated earlier, no MAR or contract is applicable, therefore, Mid-Town's usual and customary must be paid."

Amount in Dispute: $10,566.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the dispute filed by Midtown Surgery Center. The dispute appears to be a fee dispute for ambulatory surgery center charges. We continue to believe that the requestor is not entitled to additional reimbursement."

Response Submitted by: The Zenith, 1101 Capital of Texas Hwy, South, Bldg. J, Austin, TX 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2003	Outpatient Surgery	$10,566.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 29, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 4, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 226, G – Incuded in global charge.
   - 248, U – Patient convenient items are not payable.
   - 711, M – Reduced to F&R accd'g to Sec 413.011 of Act based on TWCC's deter of F&R for I/P hsp svcs & Medicare's deter of F&R pmt for ASC svcs.
   - 790, F – This charge was reduced in accordance to the Texas Medical Fee Guideline.
   - M – No MAR
   - G - Unbundling
   - U – Unnecessary treatment (without peer review)

Findings

1. The carrier denied services using the denial code U - " Unnecessary treatment (without peer review)" for services they deemed as patient convenience items. In accordance with Texas Administrative Code Section 133.301(a), which states in part, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134..." The above denial reason is not support. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
3. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "the insurance carriers must comply with TWCC Rule 133.1(a)(8) which clearly defines 'fair and reasonable' as the lesser of usual and necessary charges, MAR or negotiated contract. Your reimbursement rate is not in compliance with this requirement or definition of 'fair and reasonable'. As stated earlier, no MAR or contract is applicable, therefore, Mid-Town's usual and customary must be paid."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the comparison of charges to other carriers was not presented for review.

- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.